AMERICANS FOR
LIMITED GOVERNMENT

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Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9992-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

Submitted Electronically Via Regulations.gov

**RE: Comments of Americans for Limited Government on RIN 0938-AQ07 Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act**

To Whom It May Concern:

These comments are submitted pursuant to the Interim Final Rule that was published by the Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services (herein after "Secretary" or "Secretaries") on June 17, 2010 at 75 Fed. Reg. 41726. The Interim Final Rule implements the prohibition of the use of cost-sharing mechanisms for certain "recommended preventive services" as required by Public Law 111-148, the Patient Protection and Affordable Care Act (hereinafter "Act").

As will be discussed below, our concern with this Interim Final Rule lies primarily in the efforts by the Secretaries to describe this rule as having a cost-savings benefit while supplying insufficient evidence to back such a claim and ignoring evidence to the contrary.

**Relevant Authority**

The Interim Final Rule was promulgated to implement Section 1001(5) of the Act which amends the Public Health and Service Act by adding to it Section 2713. That section states as follows:

> Sec. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.
>
> (a) In General.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for--
>
> (1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;
>
> (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
>
> (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
>
> (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.
>
> (5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.
>
> Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

Thus the Secretary issued the Interim Final Rule.

## Analysis of the Alleged Benefits of the Rule

### Debunking the Cost-Savings Claim

The Secretary's claim that this rule will result in net cost-savings lacks supporting evidence. The examples of cost-saving preventive services are weak at best, and they ignore both statements made by the Congressional Budget Office (CBO) and other research (including one source referenced in the regulation itself) suggesting that most preventive services will *not* result in net cost savings.

Admittedly, the Secretary does not have the discretion not to implement the Act. The Secretary is, however, under no obligation to prove that implementing the act will result in cost-savings. Instead, they have a duty to be honest to the American people about the true costs of this regulation.

*Examples of Cost-Savings Given by the Rule*

The Secretary gives four examples to justify the assertion that this rule will result in cost-savings: childhood immunizations, discussing the use of aspirin with high-risk individuals, tobacco use screening and intervention, and obesity screening and counseling.

While the lack of a co-pay would probably encourage one who is obese to seek diet counseling, the prohibition on cost-sharing for two of these recommendation examples will have no impact on how often they are utilized. The Secretary offers no evidence that prohibiting co-pays will encourage a patient to go to the doctor for an aspirin, to be told not to smoke, or to be told that he or she is obese. Patients do not say, "I need a doctor to tell me not to smoke. I would go to the office to have him tell me this, but I don't want to pay the co-pay." These purported cost-savings services are not suitable examples.

And, while childhood immunizations offer clear cost-savings, they are not the only ones required by the Act. Adult immunizations do not offer the same cost-savings effectiveness as those for children.[1]

But even if each example given by the Secretary was a suitable example of cost-savings by increasing access to preventive services, at the very best, the Secretary has committed the logical fallacy of composition by assuming that because certain parts of the whole are cost-saving, the entire list of recommended preventive services as a whole is also cost-saving.

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[1] For example, a study referenced by the Secretary in this rule gave childhood immunizations a cost-efficiency rating of 5 meaning that it is cost-saving. The same study gave tentanus-diptheria booster for adults its lowest cost-efficiency rating of 1 meaning that it costs between $165,000 and $450,000 for each "quality of life year" (QALY) saved. Michael V. Maciosek et al., *Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis*, 31 Am. J. Preventive Med. 52, 54-55 (2006).

The truth is that empirical research shows that making the utilization of preventive services more universal will increase—not decrease costs. The Secretary chose to ignore such evidence.

*Literature on Costs of Preventive Services Omitted from Regulation*

Such evidence is not obscure. A 2008 study published in the *New England Journal of Medicine*, examined 599 studies that examined the cost-effectiveness of preventive services. The study reported that "[a]lthough some preventive measures do save money, the vast majority reviewed in the health economics literature do not."[2] The results showed that fewer than 20% of the services surveyed provided cost-savings.

Similarly, in a study cited by the Secretary in the Rule to demonstrate cost-savings, only 5 out of 25 (20%) preventive services listed were actually categorized by the study as having a cost-saving cost-effectiveness rating.[3]

*Congressional Budget Office*

Indeed, after examining the evidence, the Director of the Congressional Budget Office, Douglas W. Elmendorf, in a letter to Congressman Nathan Deal ( R-GA), stated that "[T]he evidence suggests that for most preventive services, expanded utilization leads to higher, not lower, medical spending overall."[4]

**Conclusion**

It is clear that the Secretary has not considered all of the evidence on whether this rule will produce net cost-savings. Indeed, there is significant data to the contrary. As such, the Interim Final Rule should be rescinded and a new Notice of Proposed Rulemaking should be published that considers all relevant evidence related to whether the net effect of this rule will produce cost-savings.

Sincerely,

William Wilson
President

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[2] Joshua T. Cohen et al., 358 New Eng. J. Med. 661, 662-663 (2008).
[3] Maciosek, *supra* note 1, *at* 52.
[4] Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to the Honorable Nathan Deal, Ranking Member, Subcomm. on Health of the Comm. on Energy and Commerce of the U.S. House of Representatives, (August 7, 2009).